# TITLE XIX MEDICAID STATE PLAN INDEX

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*GENERAL PROGRAM ADMINISTRATION*

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

*Citation*

42 CFR
430.10

(Omitted
45 CFR
Part 201,
AT-70-141)

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

DEPARTMENT OF SOCIAL ANO HEALTH SERVICES
(Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Revision:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

| *Citation* | 1.1 | Designation and Authority |
|---|---|---|
| 42 CFR 431.10<br>AT-79-29 | (a) | The Department of Social and Health Services is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)<br><br>ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program. |

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| *Citation* | | |
|---|---|---|
| | 1.1 | Designation and Authority (cont.) |
| Sec.1902(a) of the Act | (b) | The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated try administer or supervise the administration of that part of this plan which relates to blind individuals. |

/ / Yes. The state agency so designated is _____

_____.
This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

/X/ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

Revision: HCFA-AT-80-38 (BPP)
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

*Citation* 1.1 Designation and Authority (cont.)

Intergovernmental Cooperation Act of 1968

(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

/ / Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

/ / Not applicable. Waivers are no longer in effect.

/X/ Not applicable. No waivers have ever been granted.

Revision:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| *Citation* | 1.1 | Designation and Authority (cont.) | | |
|---|---|---|---|---|
| 42 CFR 431.10<br>AT-79-29 | | (d) | /X/ | The agency named in paragraph 1.1 (a) has responsibility for all determination of eligibility for Medicaid under this plan. |
| | | | / / | Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 1.2-A. there is a written agreement between the agency named in paragraph 1.1 (A) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies. |

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| *Citation* | 1.1 | Designation and Authority (cont.) |
|---|---|---|
| 42 CFR 431.10<br>AT-79-29 | (e) | All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act. |
| | (f) | All other requirements of 42 CFR 431.10 are met. |

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

*Citation* 1.2 Organization for Administration

42 CFR 431.11
AT-79-29

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the Medical Assistance Administration has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1 (a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

/X/ Not applicable. Only staff of the agency named in paragraph 1.1 (a) make such determinations.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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| *Citation* | 1.3 | Statewide Operation |
|---|---|---|
| 42 CFR 431.50 (b) AT-79-29 | | The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50. |

/X/ The plan is State administered.

/ / The plan is administered by the political subdivisions of the State and is mandatory on them.

Revision: HCFA AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| *Citation* | 1.4 | State Medical Care Advisory Committee |
|---|---|---|
| 42 CFR 431.12(b) AT-78-90 | | There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12. |
| 42 CFR 438.104 | X | The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials. |

REVISION: HCFA-PM-94-3 (MB)
April 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

*Citation* 1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

REVISION: HCFA-PM-94-3 (MB)
April 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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State/Territory: WASHINGTON

*Citation* 1.5 Pediatric Immunization Program (cont.)

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

/ / State Medicaid Agency

/X/ State Public Health Agency

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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State/Territory: WASHINGTON

| *Citation* | 1.6 | Managed Care |
|---|---|---|
| 42 CFR 438 | 1. | General Description of the Program |

a. The programs are: Healthy Options (HO), provided through contracts with Managed Care Organizations (MCOs); and a Primary Care Case Management (PCCM) program for American Indians/Alaska Natives (AI/AN), provided through contracts with tribal Indian Health Service and urban Indian clinics. Note: the acronym PCCM is used interchangeably for Primary Care Case Management as well as for the contractor for Primary Care Case Management, (i.e., Primary Care Case Managers), and should be taken in context.

b. Through a contract with the State of Washington Health Care Authority (HCA), the state also operates Medicaid managed care programs called Basic Health Plus (BH+) and the Maternity Support Program. The BH+ program is to allow Medicaid-eligible children to remain with their families who are already enrolled in Basic Health, the state-funded-only managed care program. The Maternity Support Program is to allow pregnant enrollees in Basic Health to maintain their enrollment with their MCO for the time period they are Medicaid-eligible. The HCA contracts with MCOs to provide both the state-funded-only and Medicaid programs. The BH+ and Maternity Support Program benefits are identical to HO. The BH+ and Maternity Support Program are required to meet the same federal and state requirements that HO must meet. Any state commitment described herein for HO applies also for BH+ and the Maternity Support Program.

c. All Medicaid beneficiaries described in section 3 are required to enroll in MCOs contracted for HO. Beneficiaries described in section 2b will not be mandatorily enrolled in HO or PCCM. Beneficiaries described in section 4 are excluded from HO and PCCM. Only AI/ANs, or those traditionally served by tribal or IHS clinics, may enroll in the PCCM program.

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MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

*Citation* 1.6 1.Managed Care (cont'd)

42 CFR 438

d. The objectives of HO and PCCM are to reduce costs, reduce inappropriate utilization, and assure adequate access to quality health care for Medicaid beneficiaries.

e. HO and PCCM are intended to enroll Medicaid beneficiaries in MCOs or PCCMs, which will provide or authorize all primary care services and all necessary specialty services for enrollees. The MCO or PCCM is responsible for monitoring enrollees' care and their utilization of nonemergency services. Enrollees' access to emergency and family planning services are not restricted under this program.

f. The MCO or PCCM will assist enrollees in gaining access to the health care system and, on an ongoing basis, will monitor enrollees' condition, health care needs, and service delivery. The MCO or PCCM will be responsible for either providing or locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of enrollees in the MCO or PCCM.

g. Enrollees under HO or PCCM will be restricted to receiving services included under the HO or PCCM through their enrolled MCO or PCCM. The enrollee's health care delivery will be managed by the MCO or PCCM. HO and PCCM programs are intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. The program will also enhance continuity of care and efficient and effective service delivery.

42 CFR 438.52

h. Potential enrollees will have a choice of at least two MCOs. Enrollment is continuous so enrollees may change MCOs at any time. The State is responsible for enrollment, but the State and MCOs will cooperate in providing potential enrollees with sufficient information to make informed decisions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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*Citation* 1.6 1.Managed Care (cont'd)

42 CFR 214

i. The State requires recipients to obtain services from only those providers qualified to provide Medicaid services that have not been excluded or debarred from Medicaid participation.

k. PCCM and HO are existing programs, but the state continues to actively seek stakeholder input through statewide and community standing committees which are open to MCO, PCCMs, other state and local agencies, community representatives, and Medicaid clients. When the state anticipates and implements changes to the programs, it also seeks input from its stakeholders through standing and ad hoc exchange mediums. Examples of the State's commitment to seeking stakeholder input are:

(1) The State chairs the Title XIX Advisory Committee that meets bimonthly. The committee provides an avenue for stakeholder input on all major issues concerning Title XIX, including PCCM and HO. The committee membership includes State staff, client advocates, providers, provider professional organizations, MCOs, public health organizations, and Indian tribes.

(2) Since the beginning of the Healthy Options program, the State staff responsible for day-to-day administration of the program have held standing open meetings in every region of the state. The timing of the meetings has varied from monthly to quarterly. The meetings are open to all stakeholders and are for stakeholders to voice issues, large and small, regarding Medicaid managed care.

(3) When a large change in the managed care programs is contemplated, such as the changes requested in the State's recent 1115 waiver request, the State has advertised and held facilitated, statewide meetings with stakeholders to provide information and solicit and respond to input.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

*Citation* 1.6 2. Managed Care (cont'd)

2. Assurances

a. Consistent with this description, the State assures that it meets applicable requirement of the following statute and regulations:

(1) Section 1903(m) of the Social Security Act (the Act) for MCOs and MCO contracts.

(2) Section 1905 (t) of the Act for PCCM and PCCM contracts.

(3) Section 1932 of the Act, including Section (a)(1)(A) for the State's option to limit freedom of choice by requiring recipients to receive their benefits through managed care organizations.

(4) 42 CFR 438 for MCOs and PCCMs.

(5) 42 CFR 434, including 42 CFR 434.6 of the general requirements for contracts.

(6) 42 CFR 438.6(c) of the regulations for payments under any risk contracts.

(7) 42 CFR 447.362 for payments under any non-risk contracts.

(8) 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905(a)(4)(C).

(9) 45 CFR part 74 for procurement of contracts.

42 CFR 438.50

b. The State assures that it will not require the following groups to mandatorily enroll in HO. The State's Automated Client Eligibility System (ACES) and Medicaid Management Information System (MMIS) gather eligibility information and have identifiers for all categories of eligibility. Indians who are members of

*Citation* 1.6 2. Managed Care (cont'd)

Federally qualified tribes self-identify in the enrollment process. Specific SSI information is provided through SSA SDX. Specific Title V information is passed from the State's Department of Health. Other eligibility determinations are made by State staff and entered into ACES/MMIS. Dual-eligibles, children served under 1902(e)(3) of the Act, and title IV-E are identified in the enrollment process or when they become eligible for those programs and entered into the ACES/MMIS systems, which have coding which identifies them.

(1) Medicare eligibles. Medicare eligibles are not eligible to enroll in HO.

(2) Indians who are members of Federally recognized tribes. Indians who are members of Federally recognized tribes may choose to be in the State's fee-for-service program or may voluntarily enroll in HO if they are not also members of an eligibility group that is otherwise excluded from HO enrollment.

(3) Individuals receiving SSI benefits under Title XVI. Individuals receiving SSI benefits under Title XVI are not eligible to enroll in HO.

(4) Children under 19 years of age who are:

(A) Receiving SSI benefits under title XVI. Children receiving services under Title XVI are not eligible to enroll in HO.

(B) Eligible under section 1902(e)(3) of the Act. Children receiving services under section 1902(e)(3) of the Act are not eligible to enroll in HO.

(C) In foster care or other out-of-home placement. Children receiving services in foster care or other out-of-home placement are not eligible to enroll in HO.

*Citation* 1.6 2. Managed Care (cont'd)

(D) Receiving foster care or adoption assistance. Children receiving foster care or adoption assistance are not eligible to enroll in HO.

(E) Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. Children receiving services through Title V may voluntarily enroll in HO.

c. It is the State's intent that HO be available throughout the State. HO will be implemented statewide. Mandatory enrollment provisions will not be implemented unless a choice of at least two MCOs is available.

42 CFR 438.58

d. The State has safeguards in effect to guard against conflict of interest on the part of employees of the State and its agents.

e. Through reporting from the State's Department of Health (DOH), the State identifies children receiving family-centered, community-based services through a coordinated-care system administered by DOH and provided through local health departments. The services are funded under section 501(a)(1)(D) of title V. Children so identified may request exemption/disenrollment from HO at any time without cause by contacting the State.

3. Included Populations

a. Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

b. Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC).

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*Citation* 1.6 4. Managed Care (cont'd)

4. Excluded Populations

a. Persons having Medicare coverage

b. Persons receiving services through the State's Title XXI SCHIP program

c. Persons with other health insurance, which the State considers comparable to HO coverage.

d. See also populations which are identified as excluded in 1.6, 2.b. of this section.

42 CFR 438.50

5. Enrollment and Disenrollment

a. In accordance with 42 CFR 438.52, all recipients will be given the opportunity to choose from at least two MCOs. The State will not mandatorily enroll recipients if two MCOs are not available.

42 CFR 438.50

b. The State will have the following process for default HO enrollment for potential enrollees who do not choose a MCO:

The State will determine the total capacity of all MCOs receiving assignments in each service area. Each MCO's capacity in each service area will be divided by the total capacity of all MCOs receiving assignments in each service area. The result of the calculation will be multiplied by the total of the households to be assigned. The State will assign the number of households determined by the calculation to the Contractor. The State will not make any assignments of enrollees to an MCO in a service area if the MCOs enrollment, when the State calculates assignments, is ninety percent (90%) or more of its capacity in that service area.

MCOs may choose not to receive assignments or limit assignments in any service area by so notifying the State in writing. The State reserves the right to make no assignments, or to withhold or limit assignments to

*Citation* 1.6 5. Managed Care (cont'd)

any MCO when it is in the best interest of the State. If either the MCO or the State limits assignments as described herein, the Contractor's capacity, only for the purposes of the calculation of assignments, will be that limit.

Assigned enrollees are notified by the State of their assignment and may choose a different managed care organization prior to the effective date of their assignment.

Recipients eligible for HO have from sixty to ninety days to choose an MCO, depending on the timing of eligibility determination. Recipients are notified by mail of their assignment and have from thirty to sixty days to choose another MCO, depending on the timing of eligibility.

c. The State collects information about all newly created managed care segments. At the time monthly health plan premiums are paid, the State looks at each new enrollee to see how they were enrolled into HO.

The "overall" rate looks at all new managed care enrollment segments to determine how they got to their plan. An "S" (for "selected") or an "A" (for "assigned") is attached to each HO enrollment segment in MMIS. The State looks at the total number of enrollees with a new segment and calculates the percentage of those who selected a plan and those who were assigned. The calculation includes enrollees who changed from one plan to another, who are a new family member, and who have had a short break in coverage.

The "newly eligible" rate looks at the date a client's information comes to MMIS from ACES. If there has been a break in service that is greater than 3 months, the State looks at the "A" or "S" indicator on their managed care enrollment segment to determine how they got to the plan. The State then takes the number

*Citation* 1.6 5. Managed Care (cont'd)

of "newly eligible" people and looks at the percentages of assignments and voluntary selections for the rate.

The rate of voluntary vs. assigned is examined and trended over time and has, and may again if necessary, become the focus of a quality improvement effort if the State finds the percentage or increasing trend in "A" assignments disturbing. After the prior successful quality improvement effort, the trend would be considered disturbing if it has any long-term (measured over a full year) significant increase.

42 CFR 438.50

d. Through the MMIS, State has procedures in place to identify the prior MCO, and re-enrolls an enrollee who is terminated from an MCO solely because the enrollee lost his or her Medicaid eligibility with that prior MCO when the enrollee is subsequently determined to be Medicaid- and HO-eligible.

e. If a recipient has a prior provider relationship that they wish to maintain, the State will, to the best of its abilities, assist the recipient in choosing an MCO that will maintain this relationship. The potential enrollee can identify the provider on the enrollment form or through telephone contact with the State.

f. HO enrollees may change MCOs at any time. AI/AN PCCM enrollees may switch to HO or FFS at any time. Non-AI/AN PCCM enrollees may switch to HO at any time.

g. MCOs and PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

h. MCOs and PCCMs will not terminate enrollment because of an adverse change in the recipient's health.

i. In accordance with 42 CFR 438.56(d)(2), if an enrollee's needs cannot be reasonably met by HO, the enrollee may request, and State may grant, an

*Citation* 1.6 5. Managed Care (cont'd)

exemption from mandatory participation in HO. Reasons for exemption include medical needs which cannot be met by managed care, homelessness, and
language barriers. Participation in PCCM is not mandatory.

j. At the time of enrollment, the State will inform potential enrollees of their disenrollment and exemption rights.

k. An enrollee will be allowed to choose his or her health professional in the MCO and PCCM to the extent possible and appropriate and may change his or her health professional anytime without cause.

42 CFR 438.50

l. Enrollees will have access to specialists to the extent possible and appropriate, and female enrollees will have direct access to any women's health specialist within the MCO's network. Female enrollees in PCCMs have access to any FFS women's health specialist.

m. Since the State's managed care program is long standing, all of the current contractors are traditional Medicaid providers and the State makes its best efforts to preserve the State's and its recipients' relationship with those providers.

n. Recipients who are already enrolled with an MCO or PCCM will be given priority to continue enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment.

o. Tribal members will be enrolled in the appropriate tribal or Indian Health Service (IHS) PCCM, but may choose either the HO or FFS programs prior to or at any time after PCCM enrollment.

p. The State allows the MCOs and PCCMs to request and be granted the disenrollment of enrollees only if the

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*Citation* 1.6 5. Managed Care (cont'd)

42 CFR 438

enrollee poses an unreasonable threat to staff or other patients.

q. HO enrollees may change plans at any time, with the change to become effective the next month if the request is before enrollment cut-off and the month following that month if it is after cut-off. Enrollment is for whole months for both HO and PCCM.

r. Potential enrollees or current enrollees, including those whose enrollment is voluntary, may request exemption from managed care in writing or by telephone through the Exception Case Management section of the State's Medical Assistance Administration. Those individuals for whom enrollment is not mandatory are removed upon request.

6. Payment/Contracts

a. The contracts with MCOs for HO are comprehensive risk contracts.

b. The contracts with MCOs for HO provide for capitation payments for services.

42 CFR 438

c. Capitation payments meet the requirements of 42 CFR 438.6.

d. Contracts for MCO services for HO will be competitively procured or will be available to all qualified MCOs.

e. The contractors for PCCM are federally-recognized tribes and IHS or urban Indian clinics. PCCMs are paid a $3.00 per-member-per-month (PMPM) case management fee. Services provided through PCCM are paid for FFS, including the IHS encounter rate or the FQHC encounter rate if the PCCM is an IHS clinic or an FQHC.

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*Citation* 1.6 6.Managed Care (cont'd)

f. The service areas for each MCO are identified in contract.

g. HO Non-Covered Services, described in section 7, are not included in any calculation of capitation payments.

h. The populations included/excluded from HO and PCCM are described in sections 3 and 4.

i. Neither MCOs nor PCCMs are paid any bonuses or incentives.

7. Covered/Non-Covered Services

a. PCCMs and MCOs will cover only those services described in this title XIX, Medicaid State Plan.

b. Services covered/non-covered by MCOs and services covered/non-covered by the State FFS will be described in MCO HO contracts and, for enrollees and potential enrollees, in information provided by the State and/or MCO. Pages 9u through 9y describe services covered by MCOs vs. FFS. The following FFS program services are excluded from HO:

(1) Chiropractic, except for EPSDT

(2) Day treatment services

(3) Dental services

(4) Detoxification (except for acute alcohol poisoning)

(5) Developmental disability services

(6) Education agency services

(7) Eyeglass frames, lenses, and fabrication

(8) First Steps Maternity Case Management and Maternity Support

(9) Gastroplasty

(10) Hearing Aids

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*Citation* 1.6 7. Managed Care (cont'd)

(11) Mental health services beyond a limited benefit described in contract

(12) Neurodevelopmental services paid for through the State's Department of Health

(13) Non-emergency transportation

(14) Parital hospitalization

(15) Personal care

(16) Protease inhibitors

(17) Skilled nursing facility services, except when provided as a short-term hospital alternative

(18) Sterilizations for those under age 21 or not meeting Federal requirements

(19) Substance abuse treatment

c. PCCM provides identical services as are provided in the Medicaid FFS program

8. Mandates

Qualifications and requirements for MCOs and PCCMs will be noted in State/MCO HO and State/PCCM contracts. Those contracts will incorporate all Federal and State requirements for such programs and will include, but not be limited to, the following mandates:

a. An MCO or PCCM will be a Medicaid-qualified provider and may not use persons/organizations excluded from the provision of Medicaid services in the provision of HO services.

42 CFR 438

b. The MCO will have a State-approved grievance process. The State provides the system for PCCM grievances.

*Citation* 1.6 8. Managed Care (cont'd)

c. The MCO or PCCM will provide or, for PCCMs, arrange for the provision of comprehensive primary health care services to all eligible Medicaid recipients who choose or are assigned to the MCO or PCCM.

d. The MCO or PCCM will refer enrollees for specialty care, hospital care, or other services when medically necessary.

e. The MCO or PCCM will make telephone access available 24-hours a day, 7 days a week. This access is to a live voice (an employee of the MCO or a representative) or an answering machine. During non-office hours, the answering machine will immediately page an on-call medical professional to make referrals for non-emergency services, handle medical problems, or give information about accessing services.

f. The MCO or PCCM will not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, physical or mental disability, national origin (except for tribal origin), or type of illness or condition, except when that illness or condition can be better treated by another provider type.

g. All subcontractors will be required to meet all pertinent requirements as those that are in effect for the MCO or PCCM.

h. The MCO will be licensed by the State of Washington, Office of the Insurance Commissioner (OIC) in order to ensure financial stability (solvency) and compliance with regulations. PCCMs will be Federally recognized tribes, IHS clinics, or urban Indian clinics.

9. Additional Requirements

a. Any marketing materials available for distribution under the Act and State statutes will be provided to the State for its review and approval to assure that the requirements of the Act and such statutes are met.

*Citation* 1.6 9. Managed Care (cont'd)

b. The MCO or PCCM will certify that no recipient will be held liable for any MCO debt as the result of insolvency or for services the State will not pay for.

c. The MCO or PCCM will include safeguards against fraud and abuse, as provided in State and Federal statutes.

d. The information provided to HO and PCCM enrollees will be in compliance with 42 CFR 483.10(i).

e. Through its ongoing day-to-day monitoring process and annual contract compliance review, the State monitors MCO and PCCM compliance with applicable provisions of 42 CFR 438 Subpart I.

f. The contracts with MCOs or PCCMs will have provisions implementing the applicable provisions of 42 CFR 438, subpart I.

10. FQHC and RHC Services

Enrollees will be provided reasonable access to FQHC and RHC services.

11. Process for Enrollment in an MCO

The following process is in effect for recipient enrollment in MCOs:

a. The State will provide the recipient with all of the following:

42 CFR 438

(1) A packet explaining the program and comparing MCOs in a chart-like format including benefits, services covered and not covered, and quality and performance indicators. Quality and performance indicators include disenrollment rates and enrollee satisfaction.

(2) A form for enrollment in the plan and selection of a plan.

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*Citation* 1.6 11. Managed Care (cont'd)

(3) A list of MCOs serving the recipient's geographical service area.

(4) A toll-free number that can be used to pose questions by telephone.

(5) Enrollee rights and responsibilities.

(6) Information explaining the grievance system.

(7) Information on how to obtain Medicaid services not covered by the MCO.

b. All materials will be translated into languages other than English as necessary and will be in an easily understood format.

c. Each recipient will notify the State by mail, fax, telephone, or in person, of his or her choice of MCOs.

d. If the recipient does not choose an MCO, the State will assign the recipient to an MCO and notify the recipient of the assignment.

e. The MCO will be informed electronically of the recipient's enrollment in that MCO.

f. The recipient will be notified of enrollment and issued an identification card.

42 CFR 438

g. Additionally, each MCO will provide the following information within a reasonable time period after notice of enrollment, and to any potential enrollee upon request:

(1) Benefits offered, the amount, duration, and scope of benefits and services available.

(2) Procedures for obtaining services.

(3) Names, locations and non-English languages spoken for current network providers, including those providers not accepting new patients.

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*Citation* 1.6

11. Managed Care (cont'd)

(4) Any restrictions on freedom of choice.

(5) The extent to which there are any restrictions concerning out-of-network providers.

(6) Policies for specialty care and services not furnished by the primary care providers.

(7) Grievance process.

(8) Other information as may required by Federal or State statute, rule, or policy.

42 CFR Subpart D

12. Monitoring of Quality of Health Care and Services, Including Access

HO Quality of Health Care and Services and enrollees' access to care will be monitored as part of each MCO's internal QIP, through the annual quality review of MCOs by the State through required internal and external quality review. PCCMs are monitored through the FFS program monitoring and are required to cooperate with State quality monitoring. Those activities are described in State/MCO Healthy Options contracts, PCCM contracts and the State quality strategy.

42 CFR 438

13. Access to Care

a. Recipients may choose any of the participating MCOs in the service areas. AI/ANs will be enrolled with a tribal, IHS, or urban Indian clinic unless they choose HO or FFS. For HO, the State will make available an MCO-certified service area map that is updated each contracting period. In addition, as per 42 CFR 434.29, within an MCO, each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

b. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the HO and PCCM programs.

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*Citation* 1.6 13. Managed Care (cont'd)

c. State-specified access standards for distances and travel miles to obtain services for recipients under the HO program have been established.

d. Primary care and health education are provided to enrollees by a chosen or assigned MCO or PCCM. This fosters continuity of care and improved provider/patient relationships.

e. Pre-authorization is precluded for emergency/post stabilization and family planning services under the HO and PCCM programs.

42 CFR 438.206

f. MCOs and PCCMs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

g. HO and PCCM enrollees have an equivalent or better appeals system as is in effect under the Medicaid fee-for-service program. Recipients have available a formal appeals process under 42 CFR Part 438, Subpart F.

h. The State assures that State-determined access standards are monitored on an on-going basis.

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1.6 14. Managed Care (cont'd)

14. Services Covered by MCOs vs. FFS

| **Service**<br><br>**(1)** | **State Plan Approved**<br><br>**(2)** | **1915(b)(3) Waiver Services**<br><br>**(3)** | **MCO/PHP Capitated Reimburse-ment**<br>**(4)** | **Fee-for-Service Reimburse-ment**<br>**(5)** | **Fee-for-Service Reimbursement impacted by MCO/PHP**<br>**(6)** |
|---|---|---|---|---|---|
| Day Treatment Services | X | | | X | |
| Dental | X | | | X | |
| Detoxification | X | | | X | |
| Developmental Disabilities Services (please explain) *(ICF/MR) Developmentally disabled clients receive medical services fee for service through the ICF/MR* | X | | | X | |
| Durable Medical Equipment *(Except Hearing Aides)* | X | | X | | |
| Education Agency Services *(School-Based Services for Special Education Prog.)* | X | | | X | |
| Emergency Services | X | | X | | |
| EPSDT *(Including Chiropractic)* | X | | X | | |

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1.6 14. Managed Care (cont'd)

| **Service**<br><br>**(1)** | **State Plan Approved**<br><br>**(2)** | **1915(b)(3) Waiver Services**<br><br>**(3)** | **MCO/PHP Capitated Reimburse-ment**<br>**(4)** | **Fee-for-Service Reimburse-ment**<br>**(5)** | **Fee-for-Service Reimbursement impacted by MCO/PHP**<br>**(6)** |
|---|---|---|---|---|---|
| Family Planning Services. *Note: HO members may seek family planning services through the plan, or may self-refer to the local health dept. or family planning agency.* | X | | X | X | |
| Federally Qualified Health Center Services | X | | X | | |
| Hearing Aids | X | | | X | |
| Home Health | X | | X | | |
| Hospice | X | | X | | |
| Inpatient Hospital - Psych | X | | | X | |
| Inpatient Hospital | X | | X | | |
| Immunizations – *HO members may receive immunizations from their PCP, or self-refer to their local health dept*. | X | | X | X | |
| Maternity Case Management/Maternit y Support Services | X | | X | X | |
| Lab and x-ray | X | | X | | |

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1.6 14. Managed Care (cont'd)

| **Service**<br><br>**(1)** | **State Plan Approved**<br><br>**(2)** | **1915(b)(3) Waiver Services**<br><br>**(3)** | **MCO/PHP Capitated Reimburse-ment**<br>**(4)** | **Fee-for-Service Reimburse-ment**<br>**(5)** | **Fee-for-Service Reimbursement impacted by MCO/PHP**<br>**(6)** |
|---|---|---|---|---|---|
| Mental Health Services *The 2001 HO contract requires 1 evaluation per year for adults and as necessary for children; also, medication mgt. and 12 visits to m.h. professional are covered. Clients may receive services from plan or self- refer to community mental health.* | X | | X | X | |
| Nurse midwife | X | | X | | |
| Nurse practitioner | X | | X | | |
| Nursing Facility | X | | | X | |
| Obstetrical services | X | | X | | |
| Occupational therapy | X | | X | | |
| Other fee-for-service services | X | | | X | |
| Other Outpatient Services -- Please Specify | | | | | |
| Other Psych Practitioner | | | | | |
| Outpatient Hospital - All Other | X | | X | | |

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1.6 14. Managed Care (cont'd)

| **Service**<br><br>**(1)** | **State Plan Approved**<br><br>**(2)** | **1915(b)(3) Waiver Services**<br><br>**(3)** | **MCO/PHP Capitated Reimburse-ment**<br>**(4)** | **Fee-for-Service Reimburse-ment**<br>**(5)** | **Fee-for-Service Reimbursement impacted by MCO/PHP**<br>**(6)** |
|---|---|---|---|---|---|
| Outpatient Hospital - Lab & X-ray | X | | X | | |
| Partial Hospitalization | X | | | X | |
| Personal Care | X | | | X | |
| Pharmacy | X | | X | | |
| Physical Therapy | X | | X | | |
| Physician | X | | X | | |
| Private duty nursing | X | | X | | |
| Prof. & Clinic and other Lab and X-ray | X | | X | | |
| Psychologist *(Service may be covered either by ffs or through MCO depending on referral process)* | X | | X | X | |
| Rehabilitation Treatment Services | X | | X | | |
| Respiratory care | X | | X | | |
| Rural Health Clinic | X | | X | | |
| Speech Therapy | X | | X | | |
| Substance Abuse Treatment Services | X | | | X | |

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1.6 14. Managed Care (cont'd)

| **Service**<br><br>**(1)** | **State Plan Approved**<br><br>**(2)** | **1915(b)(3) Waiver Services**<br><br>**(3)** | **MCO/PHP Capitated Reimburse-ment**<br>**(4)** | **Fee-for-Service Reimburse-ment**<br>**(5)** | **Fee-for-Service Reimbursement impacted by MCO/PHP**<br>**(6)** |
|---|---|---|---|---|---|
| Testing for sexually-transmitted diseases (STDs)<br>*NOTE: HO members may receive these services through the plan or may self-refer to the local health dept.* | X | | X | X | |
| Transportation – Emergency | X | | X | | |
| Transportation - Non-emergency | X | | | X | |
| Vision Exams and Glasses *(Vision exams covered by MCOs, hardware covered ffs)* | X | | X | X | |
| Other -- Please specify | | | | | |
| Other Pharmacy Services -- Please specify (e.g., Health Drugs) | | | | | |
| Other Mental Health Services – Please Specify | | | | | |
| Other Inpatient Services – Please Specify | | | | | |

REVISION: HCFA-PM-91-4 (BPD) OMD No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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SECTION 2 - COVERAGE AND ELIGIBILITY

| Citation | | |
|---|---|---|
| 42 CFR 435.10 and Subpart J | 2.1 | Application, Determination of Eligibility and Furnishing Medicaid |
| | (a) | The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid. |
| (Omitted Part 435, AT – 79 - 29 AT – 80 - 34) | | |

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| Citation | | | |
|---|---|---|---|
| 42 CFR 435.914 1902(a)(34) of the Act | 2.1(b) | (1) | Except as provided in items 2.1 (b) (2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A. |
| 1902(e)(8) and 1905(a) of the Act | | (2) | For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902 (a) (10) (E) (i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-a specifies the requirements for determination of eligibility for this group. |
| 1902(a)(47) and | | / /(3) | Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-a specifies the requirements for determination of eligibility for this group. |
| 42 CFR 438.6 | (c) | | The Medicaid agency elects to enter into a risk contract that complies with 42 CFR 438.6, and that is procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply): |

/ / Qualified under title XIII 1310 of the Public Health Services Act

/X/ A Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2.

/X/ A Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2.

/X/ A Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

/ / Not applicable.

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October 1991

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| Citation | | |
|---|---|---|
| 1902(a)(55) of the Act | 2.1(d) | The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions. |

REVISION: HCFA-PM-91-4 (BPD) OMB No. 0938
August 1991

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Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

/ / Mandatory categorically needy and other required special groups only.

/ / Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

/ / Mandatory categorically needy, other required special groups, and specified optional groups.

/X/ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, 1925 of the Act are met.

REVISION: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
March 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405) | 2.3 | Residence<br><br>Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address. |

REVISION: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
March 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 2.4 | Blindness |
|---|---|---|
| 42 CFR 435.530(b)<br>42 CFR 435.531<br>AT-78-90<br>AT-79-29 | | All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2 . 2-A . |

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 435.121, 435.540(b) 435.541 | 2.5 | Disability<br><br>All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan. |

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 435.10 and Subparts G & H<br><br>1902(a)(10)(A)(i)(III), (IV), (V), and (VI), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902(r)(2), and 1920 of the Act | 2.6 | Financial Eligibility |
| | (a) | The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A. |

REVISION: HCFA-PM-86-20 (BERC) OMB No.: 0938- 0193
September 1986

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 2.7 | Medicaid Furnished Out of State |
|---|---|---|
| 431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529) | | Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State; and<br><br>An eligible individual who is a resident of the state when care is provided in Canada under the conditions specified in Attachment 2.7-A. |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(l) Categorically needy

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(I) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife if under the supervision of, or associated with, a physician or other health care provider.

/ / Not applicable. Nurse-midwives are not authorized to practice in this state.

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | 3.1(a) (1) Amount, Duration, and Scope of Services: Categorically Needy (Continued) |
|---|---|---|---|
| 1902(e) (5) of the Act | | (iii) | Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends. |
| | /X/ | (iv) | Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women. |
| 1902(a) (10) (F) (VII) | | (v) | Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a) (10) (A) (i) (IV) and 1902(a) (10) (A) (ii) (IX) of the Act. |

REVISION: HCFA-PM-92-7 (MB)
October 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 3.1(a)(1) | Amount, Duration, and Scope of Services: Categorically Needy (Continued) | |
|---|---|---|---|
| | | (vi) | Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan. |
| 1902(e)(7) of the Act | | (vii) | Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished. |
| 1902(e)(9) of the Act | /X/ | (viii) | Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan. |
| 1902(a)(52) and 1925 of the Act | | (ix) | Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan. |
| 1905(a)(23) and 1929 | / / | (x) | Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A. |

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

REVISION: HCFA-PM-92-7 (MB)
October 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 3.1 | Amount, Duration, and Scope of Services (continued) |
|---|---|---|
| 42 CFR Part 440, Subpart B | (a)(2) | Medically needy. |
| | /X/ | This state plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided. |
| | | Services for the medically needy include: |
| 1902(a)(10)(C)(iv)(i) of the Act 42 CFR 440.220 | | If services in an institution for mental diseases* or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act. *(42 CFR 440.140 and 440.160). |
| | | / / Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State. |
| 1902(e)(5) of the Act | (ii) | Prenatal care and delivery services for pregnant women. |

REVISION: HCFA-PM-91-4 (PBD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued) |
|---|---|---|---|
| | | (iii) | Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends. |
| | /X/ | (iv) | Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women. |
| | | (v) | Ambulatory services, as defined in ATTACHMENT 3.1B, for recipients under age 18 and recipients entitled to institutional services. |
| | | | / / Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy. |
| | | (vi) | Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan. |
| 43 CFR 440.140,. 440.150, 440.160 Subpart B, | /X/ | (vii) | Services in an institution for mental diseases for individuals over age 65. |
| 443.441, Subpart C | /X/ | (viii) | Services in an intermediate care facility for the mentally retarded. |
| 1902(a)(10)(C) | | (ix) | Inpatient psychiatric services for individuals under age 21. |

REVISION: HCFA-PM-93-5 (MB)
May 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | |
|---|---|---|---|
| | 3.1(a)(2) | | Amount, Duration, and Scope of Services: Medically Needy (Continued) |
| 1902(e)(9) of Act | /X/ | (x) | Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan. |
| 1905(a)(23) and 1929 of the Act | | (xi) | Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A. |

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

*Citation* 3.1 Amount. Duration, and Scope of Services (continued)

(a)(3) Other Required Special Groups: Qualified Medicare Beneficiaries

Medicare cost sharing for qualified Medicare beneficiaries described in section 1902(a)(10)(E)(i) and 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.

(a)(4)(i) Other Required Special Groups; Qualified Disabled and Working Individuals

Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.

(ii) Other Required Special Groups: Specified, Low-Income Medicare Beneficiaries

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a) (10) (E) (iii) and 1905(p) of the Act are provided as in indicated in item 3.2 of this plan.

(iii) Other Required Special Groups: Qualifying Individuals - 1

Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

(a)(5) Other Required Special Groups: Families Receiving Extended Medical Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

REVISION: HCFA-PM-98-1 (CMSO)
April 1998

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L.96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued) |
|---|---|---|---|
| 1902(a) and 1903(v) of the Act | | (iii) | Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act. |
| 1905(a)(9) of the Act | (a)(7) | | Homeless Individuals.<br><br>Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished. |
| 1902(a)(47) and 1920 of the Act | (a)(8) | | Presumptivelv Eligible Pregnant Women<br><br>Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan. |
| 42 CFR 441.55<br>50 FR 43654<br>1902(a)(43), 1905(a)(4)(B), 1905(r) of the Act | (a)(9) | | EPSDT Services.<br>The Medicaid agency meets the requirements of sections 1902(a)(43),1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, and diagnostic, and treatment (EPSDT) services. |

REVISION: HCFA-PM-91 1991 (BPD)

Comparability
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | |
|---|---|---|---|
| | 3.1(a)(9) | | Amount, Duration, and Scope of Services: EPSDT Services (continued) |
| 42 CFR 441.60 | | / / | The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.** |
| 42 CFR 440.240 and 440.250<br><br>1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4), and 1932 | (a)(10) | | Comparability of Services<br><br>Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions: |
| | | (i) | Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person. |
| | | (ii) | The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy. |
| | | (iii) | Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group. |
| | / / | (iv) | Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy. |

** Describe here
The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site visits to monitor the provider's record of case management.

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CFR Part 440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

/X/ Yes

/ / Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

/X/ Yes, to all

/ / Yes, to individuals age 21 or over; SNF services are provided

/ / Yes, to individuals under age 21; SNF services are provided

/ / No; SNF services are not provided

/ / Not applicable; the medically needy are not included under this plan

REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 3.1 | Amount, Duration, and Scope of Services (continued) |
|---|---|---|
| 42 CFR 431.53 | (c)(1) | Assurance of Transportation<br><br>Provision is made for assuring necessary providers transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D. |
| 42 CFR 483.10 | (c)(2) | Payment for Nursing Facility Services<br><br>The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (C) (8) (i) |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 440.260<br>AT-78-90 | 3.1 (d) | Methods and Standards to Assure Quality of Services<br><br>The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C. |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 3.1(e) Family Planning Services |
|---|---|
| 42 CFR 441.20<br>AT-78-90 | The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning. |

REVISION: HCFA-PM-87-5 (BERC) OMB No.: 938-0193
April 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CFR 441.30.
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

/ / Yes

/ / No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

/ / Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant .procedures are provided

/ / No

/X/ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

REVISION: HCFA-PH-87-4 (BERC) OMB No.: 938-0193
March 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act,
P.L. 99-509
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who-

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of-

/X/ 30 consecutive days;

/ / __ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/X/ Yes. The requirements of section 1902(e)(9) of the Act are met.

/ / Not applicable. These services are not included in the plan.

REVISION: HCFA-PM-93-5 (MB)
May 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary QMB

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

/X/ Part A /X/ Part B

/ / The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

REVISION: HCFA-PM-97-3 (CMSO)
December 1997

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 1902(a)(10)(E)(ii) and 1905(s) of the Act | (ii) | Qualified Disabled and Working Individual (QDWI)<br><br>The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan. |
| 1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act | (iii) | Specified Low-Income Medicare Beneficiary (SLMB)<br><br>The Medicaid agency pays Medicare Part B premiums under the State buy-In process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan. |
| 1902(a)(10)(E){iv}(I), 1905(p}(3)(A)(ii), and 1933 of the Act | (iv) | Qualifying Individual - 1 (QI-1)<br><br>The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a) (10) (E) (iv) (I) and subject to 1933 of the Act. |
| 1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act | (v) | Qualifying Individual - 2 (QI-2)<br><br>The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10) (E}(iv)(II) and subject to 1933 of the Act. |

REVISION: HCFA-PM-97-3 (CMSO)
December 1997

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

1843 (b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

/X/ All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

/ / Individuals receiving title II or Railroad Retirement benefits.

/X/ Medically needy individuals (FFP is not available for this group)

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

/X/ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 63 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

REVISION: HCFA-PM- (MB)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a),and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

/X/ For the entire range of services available under Medicare Part B.

/ / Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible -- OMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

REVISION: HCFA-PM-91-8 (MB) OMB No.:
October 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | Condition or Requirement |
|---|---|
| 1906 of the Act | (c) Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations<br><br>The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.<br><br>When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h). |
| 1902(a)(10)(F) of the Act | (d) / / The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A. |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CPR 441.101,
42 CFR 431.620 (c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

/X/ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620 (c) and (d) are met.

/ / Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 441.252<br>AT-78-99 | 3.4 | Special Requirements Applicable to Sterilization Procedures<br><br>All requirements of 42 CFR Part 441, Subpart F are met. |

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

/X/ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (o may be greater if provided through a caretaker relative employer's health insurance plan).

/ / Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

/ / Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/ / Medical or remedial care provided by licensed practitioners.

/ / Home health services.

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation 3.5 Families Receiving Extended Medicaid Benefits
(Continued)

/ / Private duty nursing services.

/ / Physical therapy and related services.

/ / Other diagnostic, screening, preventive, or rehabilitation services.

/ / Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.

/ / Intermediate care facility services for the mentally retarded.

/ / Inpatient psychiatric services for individuals under age 21.

/ / Hospice services.

/ / Respiratory care services.

/ / Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation 3.5 Families Receiving Extended Medicaid Benefits
(Continued)

(c) / / The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

/ / 1st 6 months / / 2nd 6 months

/ / The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

/ / 1st 6 mos. / / 2nd 6 mos.

(d) / / (1)The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

/ / Enrollment in the family option of an employer's health plan.

/ / Enrollment in the family option of a State employee health plan.

/ / Enrollment in the State health plan for the uninsured.

/ / Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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State/Territory: WASHINGTON

Citation 3.5 Families Receiving Extended Medicaid Benefits
(Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency-

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/ / (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

REVISION: HCFA-PN-87-4 (BERC) OMB No.: 0938-0193
March 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

| Citation | | |
|---|---|---|
| 42 CFR 431.15<br>AT-79-29 | 4.1 | Methods of Administration<br><br>The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan. |

REVISION: HCFA-ROX-1 (BPP)
November 1990

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.2 | Hearings for Applicants and Recipients |
|---|---|---|
| 42 CFR 431.202<br>AT-79-29<br>AT-80-34 | | The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E. |
| 1919(e)(3) | | With respect to transfers and discharges from nursing facilities, the requirements of 1919(e)(3) are met. |

REVISION: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
August 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.3 | Safeguarding Information on Applicants and Recipients |
|---|---|---|
| 42 CFR 431.301<br>AT-79-29 | | Under State statute which imposes legal sanctions, safeguards are provided that restrict the use of disclosure of information concerning applicants and recipients to purposed directly connected with the administration of the plan. |
| 52 FR 5967 | | All other requirements of 42 CFR Part 431, Subpart F are met. |

REVISION: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
September 1988

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 431.800(c)<br>50 FR 21839<br>1903(u)(1)(D) of the Act,<br>P.L. 99-509 (Section 9407)<br>431.800(e), | 4.4 | Medicaid Quality Control |
| | (a) | A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P. |
| | (b) | The State operates a claims processing assessment system that meets the requirements of (g) , (h), (j)*, and (k) . |
| | / / | Yes. |
| | /X/ | Not applicable. The State has an approved Medicaid Management Information System (MMIS). |

*pen & ink change to add “j” per PM 87-14, 10/87

REVISION: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
September 1988

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 455.12<br>AT-78-90<br>48 FR 3742<br>52 FR 48817 | 4.5 | Medicaid Agency Fraud Detection and Investigation Program<br><br>The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse. |

REVISION: HCFA-PM-99 (CMSO)
199

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MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| Section 1902(a)(64) of the Social Security Act<br>P.L. 105-33 | 4.5a | Medicaid Agency Fraud Detection and Investigation Program<br><br>The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title. |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.6 | Reports |
|---|---|---|
| 42 CFR 431.16<br>AT-79-29 | | The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met. |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 431.17<br>AT-79-29 | 4.7 | Maintenance of Records<br><br>The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met. |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 431.18(b)<br>AT-79-29 | 4.8 | Availability of Agency Program Manuals<br><br>Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met. |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 433.37<br>AT-78-90 | 4.9 | Reporting Provider Payments to Internal Revenue Service |

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

NEW: HCFA-PM-99-3
June 1999

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

42 CFR431.51
AT-78-90
46 FR 48524
48 FR23212
1902 (a) (23)
of the Act
P.L. 100-93
(section 8(f))
P.L.100-203
(Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual--

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or

Section 1902(a)(23)
Social Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a of the felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915 9a), 1915(b),1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

REVISION:

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4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agencies utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. These agencies are: the Department of Social and Health Services and the Department of Health.

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients are: the Legislature, State Board of Health, State Fire Marshall, the Department of Social and Health Services, and the Department of Health.

(c) Attachment 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Center for Medicare and Medicaid Services on request.

REVISION:

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State/Territory: WASHINGTON

4.11 Relations with Standard-setting and Survey Agencies – continued

(d) The Department of Social and Health Services and the Department of Health are the state agencies responsible for licensing health institutions and determine if institutions and agencies meet the requirements for participation In the Medicaid program. The requirements in 42 CFR 431.61(e), (f), and (g) are met.

REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b) .

/X/ Yes, as listed below:

Emergency medicine and trauma prevention pre-hospital system facilities and organizations.

Rural Health Clinics

Rehabilitation facilities

End Stage Renal Dialysis facilities

Ambulatory Surgery Centers

Child Birth Centers

Residential Treatment facilities

Chemical Dependency Treatment facilities

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107

(a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483
1919 of the Act

(b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483 Subpart D

(c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act

(d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

/X/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

REVISION: HCFA-PM-91-9 (BPD)
October 1991



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MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

1902(a)(58)
1902(w) 4.13

(e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph(1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law or court decision exist regarding advance directives.

Revision: HCFA-PM-91-9 (MB) EQRO
October 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation 4.14 Utilization/Quality Control

42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

_____ Directly

_____ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —

(1) Meets the requirements of §434.6(a):

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1932(c)(2)
and 1902(d) of the
meets ACT, P.L. 99-509
each (section 9431)

_X__ A qualified External Quality Review Organization performs an annual External Quality Review that the requirements of 42 CFR 438 Subpart E for managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation

REVISION: HCFA-PH-85-3 (BERC)
May 1985

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

OMB N0.
0938-0193

Citation

42 CFR 456.2
50 PR 15322

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services:

/X/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CPR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CPR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/ / All hospitals (other than mental hospitals).

/ / Those specified in the waiver.

/X/ No waivers have been granted.

REVISION: HCFA-PH-85-7 (BERC) OMB No.: 0938-0193
July 1985

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/ / All mental hospitals.

/ / Those specified in the waiver.

/X/ No waivers have been granted.

/ / Not applicable. Inpatient services in mental hospitals are not provided under this plan.

REVISION: HCFA-PH-85-3 (BERC)
May 1985

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

OMB N0. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CPR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/X/ Utilization review is performed in accordance with 42 CYR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/X/ All skilled nursing facilities.

/ / Those specified in the waiver.

/ / No waivers have been granted.

REVISION: HCFA-PH-85-3 (BERC)
May 1985

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

OMB N0. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (e) /X/ The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/ / Facility-based review.

/ / Direct review by personnel of the medical assistance unit of the State agency.

/ / Personnel under contract to the medical assistance unit of the State agency.

/ / Utilization and Quality Control Peer Review Organizations.

/ / Another method as described in ATTACHMENT 4.14-A.

/X/ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/ / Not applicable. Intermediate care facility services are not provided under this plan.

REVISION: HCFA-PH-91-10 (MB)
December 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.14 Utilization/Quality Control (Continued) |
|---|---|
| 42 CFR 438.356(e) | For each contract, the State follows an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services. |
| 42 CFR 438.354 | The State ensures that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements. |

___ Not applicable.

REVISION: HCFA-PH-92-2 (HSQB)
March 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.15 | Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals |
|---|---|---|
| 42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act | / / | The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for: |
| | | / / ICFs/MR; |
| | | / / Inpatient psychiatric facilities for recipients under age 21; and |
| | | / / Mental Hospitals. |
| 42 CFR Part 456 Subpart A and 1902(a)(30) of the Act | /X/ | All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services. |
| | / / | Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan. |
| | / / | Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan. |
| | / / | Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan. |

REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.16 | Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees |
|---|---|---|
| 42 CFR 431.615(c)<br>AT-78-90 | | The Vocational Rehabilitation Agencies are located within the Single State Agency.<br><br>The Medicaid agency has cooperative arrangements with the Title V Grantee, Department of Health, that meet the requirements of 42 CFR 431.615.<br><br>ATTACHMENT 4.16-A describes the cooperative arrangement with the Title V Grantee. |

REVISION: HCFA-PM-95-3 (MB)
May 1995

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MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

/ / The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFS 433.36(c) – (g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

/X/ The State imposes liens on real property on account of benefits incorrectly paid.

/ / The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

/X/ The State imposes liens on both real and personal property of an individual after the individual's death.

REVISION: HCFA-PM-95-3 (MB)
May 1995

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MEDICAL ASSISTANCE PROGRAM

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4.17 Liens and Adjustments or Recoveries (cont.)

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h) – (i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

/ / Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

/X/ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

All Medicaid service listed in Attachments 3.1-A and 3.1-B provided to eligible clients. Medicare cost-sharing and Medicare premiums for individuals also receiving Medicaid (dual eligibles), and premium payments to managed care organizations will be included in the statement of claim.

REVISION: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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State/Territory: WASHINGTON

4.17 Liens and Adjustments or Recoveries (cont.)

(4) / / The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy for in Attachment 2.6 – A, Supplement 8b.

/X/ The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

/ / The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

/ / The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

REVISION: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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4.17 Liens and Adjustments or Recoveries (cont.)

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h) – (i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

REVISION: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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4.17 Liens and Adjustments or Recoveries (cont.)

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36 (d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36 (f).

(3) Defines the following terms:

- estate at a minimum estate as defined under State probate law). Except for the grandfathered States listed in section 4.17 (b) (3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual has any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

REVISION: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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4.17.1 Liens and Adjustments or Recoveries (cont.)

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CFR 447.51 through 447.58

4.18 Recipient Cost Sharing and Similar Charges

(a) Unless a waiver under 42 CFR 431.55 (g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916 (a) and (b) of the Act

(b) Except as specified in items 4.18 (b) (4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905 (p) (1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under - -

/ / Age 19

/ / Age 20

/ / Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

4.18(b)(2) Recipient Cost Sharing and Similar Charges (cont.)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

/ / Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60

42 CFR 438.108

/X/ Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

/ / Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

REVISION: HCFA-AT-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation

4.18(b) Recipient Cost Sharing and Similar Charges (cont.)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

/X/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

/ / 18 or older

/ / 19 or older

/ / 20 or older

/ / 21 or older

/ / Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

REVISION: HCFA-AT-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

4 .18 (b) (3) Recipient Cost Sharing and Similar Charges (cont.)

42 CFR 447.51 through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;.

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s) ;

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/ / Not applicable. There is no maximum.

REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.18 Recipient Cost Sharing and Similar Charges (cont.) | | |
|---|---|---|---|
| 1916 (c) of the Act | 4.18(b)(4) | / / | A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(ix) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to the family of the size involved. The requirements of section 1916(c) of the Act are met. Attachment 4.18-D specifies the method the state uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients. |
| 1902(a)(52) and 1925(b) of the Act | 4.18(b)(5) | /X/ | For families receiving extended benefits during a second six-month period under section 1925 of Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act. Attachment 4.18-F specifies the method the state uses for determining the premium, exemptions from the premium requirement, the method the states uses for billing the premium, and good cause criteria for failure to pay the required premium. |
| 1916(d) of the Act | 4.18(b)(6) | /X/ | A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. Attachment 4.18-E specifies the method and standards the state uses for determining the premium. |

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| Citation | | | |
|---|---|---|---|
| | 4.18 Recipient Cost Sharing and Similar Charges (cont.) | | |
| CFR 447.51 through 447.58 | 4.18(c) | / / | Individuals are covered as medically needy 42 under the plan. |
| | (1) | / / | An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18 – B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52 (b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge. |
| 447.51 through 447.58 | (2) | | No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following: |
| | | | (i) Services to individuals under Age 18, or under – |
| | | | / / Age 19 |
| | | | / / Age 20 |
| | | | / / Age 21 |
| | | | Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable. |

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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State/Territory: WASHINGTON

| Citation | 4.18 Recipient Cost Sharing and Similar Charges (cont.) | |
|---|---|---|
| 42 CFR 447.51 through 447.58 | 4.18 (c) (2) | (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy. |
| | | (iii) All services furnished to pregnant women. |
| | | / / Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy. |
| | | (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs. |
| | | (v) Emergency services if the services meet the requirements in 42 CFR 447.53 (b) (4) . |
| | | (vi) Family planning services and supplies furnished to individuals of childbearing age. |
| 1916 of the Act, P.L. 99-272 (Section 9505) | | (vii) Services furnished to an individual receiving hospice care, as defined in section 1905 (o) of the Act. |
| 447.51 through 447.58 | | (viii) Services provided by a health maintenance organization (HMO) to enrolled individuals. |
| | | / / Not applicable. No such charges are imposed. |

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August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

4.18 Recipient Cost Sharing and Similar Charges (cont.)

4.18(c)(3) Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b) (2) above.

/ / Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

/ / 18 or older

/ / 19 or older

/ / 20 or older

/ / 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable:

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| Citation | 4.18 Recipient Cost Sharing and Similar Charges (cont) | | |
|---|---|---|---|
| 447.51 through 447.58 | 4.18 (c) (3) | (iii) | For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the: |

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) ; and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

/ / Not applicable. There is no maximum.

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.19 | Payment for Services |
|---|---|---|
| 42 CFR 447.252<br>1902(a)(13)<br>and 1923 of<br>the Act | (a) | The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services. |
| 1902(e)(7)<br>of the Act | | ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services. |

/X/ Inappropriate level of care days are covered and are paid under the State plaza at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

/ / Inappropriate level of care days are not covered.

REVISION: HCFA-PM-93-6 (MB) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.19 Payment for Services (cont.) | |
|---|---|---|
| 42 CFR 447.201<br>42 CFR 447.302<br>52 FR 28648<br>1902(a)(13)(E)<br>1903(a)(1) and<br>(n), 1920, and<br>1926 of the Act | 4.19(b) | In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:<br><br>(1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905 (a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).<br><br>(2) Sections 1902 (a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.<br><br>ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments. |
| 1902(a)(10) and<br>1902(a)(30) of<br>the Act | | SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance. |

REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.19 Payment for Services (cont.) | |
|---|---|---|
| 42 CFR 447.40<br>AT-78-90 | 4.19 (c) | Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility. |

/X/ Yes. The State's policy is described in ATTACHMENT 4.19-C.

/ / No.

REVISION: HCFA-PM-87-9 (BERC) OMB No.: 0938-0193
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19(d) Payment for Services (cont.)

/X/ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

/X/ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/ / Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

/X/ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/ / Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

/ / (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.19 | Payment for Services | |
|---|---|---|---|
| 42 CPR 447.45 (c)<br>AT-79-50 | 4.19 (e) | The Medicaid agency meets all requirements of 42 CPR 447.45 for timely payment of | ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements. |

REVISION: HCFA-PM-87-4 (BERC)
March 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.19 | Payment for Services |
|---|---|---|
| 42 CPR 447.15<br>AT-78-90<br>AT-80-34<br>48 FR 5730 | 4.19 (f) | The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.<br><br>No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change. |

REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.19 | Payment for Services |
|---|---|---|
| 42 CFR 447.201<br>42 CFR 447.202<br>AT-78-90 | 4.19 (g) | The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials. |

REVISION: HCFA-PM-80-60 (BPP)
August 12, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.19 | Payment for Services (cont.) |
|---|---|---|
| 42 CFR 447.201<br>42 CFR 447.203<br>42 CFR 447.203<br>AT-78-90 | 4.19 (h) | The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates. |

REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.19 | Payment for Services | |
|---|---|---|---|
| 42 CFR 447.201<br>42 CFR 447.204<br>AT-78-90 | | 4.19 (i) | The Medicaid agency's payments are sufficient try enlist enough providers so that services under the plan are available to recipients at least to the the general population. |

REVISION: HCFA-PM-91-4 (BPP) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | Payment for Services (cont.) |
|---|---|---|---|
| 42 CFR 447.201 and 447.205 | 4.19 | (j) | The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates. |
| 1903(v) of the Act | | (k) | The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act. |

REVISION: HCFA-PM-92-7 (MB) OMB No.: 0938-
October 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.19 | Payment for Services (cont.) |
|---|---|---|
| 1903(i)(14) of the Act | 4.19 (1) | The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act. |

REVISION: HCFA-PM-94-6 (MB)
OCTOBER 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation 4.19 Payment for Services (cont.)

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in1928(c) (2) (C) (ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

/ / sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

/ / is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

/ / sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

/X/ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine.

- Managed Care Plans:
  Administration rates for vaccines are factored in as part of administrative costs to the plan.

- Non-Managed Care Plan providers will be paid based on fee-for-service.

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

- State will maintain a list of Medicaid program registered providers.

- Medicaid program-registered providers who can communicate in a language and cultural context which is most appropriate will be identified.

- Vaccines will be distributed through the Managed Care Plans and other Medicaid registered providers.

- Quality Assurance program is performing outcome studies and will continue to work with Managed Care Plans to increase immunization rates.

- Children covered under Managed Care Plans may receive immunization at the Health Department, so access is not limited.

REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
42 CFR 447.25 (b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

/ / Yes, for / / physician's services

/ / dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

/X/ Not applicable. No direct payments are made to recipients.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.21 | Prohibition Against Reassignment of Provider Claims |
|---|---|---|
| 42 CFR 447.10 (c)<br>AT-78-90<br>46 FR 42699 | | Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10. |

REVISION: HCFA-PM-94-1 (MB)
February 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.22 | Third Party Liability |
|---|---|---|
| 42 CFR 433.137 | (a) | The Medicaid agency meets all requirements of:<br>(1) 42 CFR 433.138 and 433.139.<br>(2) 42 CFR 433.145 through 433.148.<br>(3) 42 CFR 433.151 through 433.154. |
| 1902 (a) (25) (H) and (I) of the Act. | | (4) Sections 1902 (a) (25) (H) and (I) of the Act. |
| 42 CFR 433.138 (f) | (b) | ATTACHMENT 4.22-A --<br>(1) Specifies the frequency with which the data exchanges required in §433.138 (d) (1), (d) (3) and (d) (4) and the diagnosis and trauma code edits required in §433,137 (e) are conducted; |
| 42 CFR 433.138 (g) (1) (ii) | | (2) Describes the methods the agency uses for meeting the following requirements continued in §433.138 (g) (1) (i) and (g) (2) (i); |
| 42 CFR 433.138 (g) (3) (i) and (iii) | | (3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138 (d) (4) (ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and |
| 42 CFR 433.138 (g) (4) (I) through (iii) | | (4) Describes the methods the agency uses for following up on paid claims identified under §433.138 (e) (methods include a procedure for periodically identifying these trauma code that yield the highest third party collections and giving priority to following up on these codes) and specifies the time frames for incorporation into the eligibility case file and into its third party date base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources. |

REVISION: HCFA-PM-94-1 (MB)
February 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.22 Third Party Liability (cont.) | | |
|---|---|---|---|
| 42 CFR 433.139 (b) (3) (ii)(A) | /X/ | (c) | Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency. |
| | | (d) | ATTACHMENT 4.22-B specifies the following: |
| 42 CFR 433.139 (b) (3) (ii) (c) | | (1) | The method used in determining a provider's compliance with the third party billing requirements at §433.139 (b) (ii) (C). |
| 42 CFR 433.139 (f) (2) | | (2) | The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective. |
| 42 CFR 433.139 (f) (3) | | (3) | The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement. |
| 42 CFR 447.20 | | (e) | The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20. |

REVISION: HCFA-PM-94-1 (MB)
February 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation — 4.22 Third Party Liability (cont.)

42 CFR 433.151 (a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

/ / State title IV-D agency. The requirements of 42 CFR 433.152 (b) are met.

/ / Other appropriate State agency(s)--
_____
_____

/ / Other appropriate agency(s) of another State--
_____
_____

/ / Courts and law enforcement officials.

1902 (a) (60) of the Act (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

/ / The Secretary's method as provided in the State Medicaid Manual, Section 3910.

/X/ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

REVISION: HCFA-PM-84-2 (BERC) OMB No.: 0938-0193
01-84

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.23 | Use of Contracts |
|---|---|---|
| 42 CFR Part 434.4<br>48 FR 54013 | | The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434. |
| | | / / Not applicable. The State has no such contracts. |

REVISION: HCFA-PM-94-2 (BPD)
April 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.24 | Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services |
|---|---|---|
| 42 CFR 442.10 and 442.100<br>AT-78-90<br>AT-79-18<br>AT-80-25<br>AT-80-34<br>52 FR 32544<br>P.L. 100-203<br>(Sec. 4211)<br>54 FR 5316<br>56 FR 48826 | | With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.<br><br>/ / Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan. |

REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 431.702<br>AT-78-90 | 4.25 | Program for Licensing Administrators of Nursing Homes<br><br>The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators. |

REVISION: HCFA-PM-93-3 (MB)
March 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| | | | |
|---|---|---|---|
| Citation 1927g 42 CFR 456.700 | 4.26 | Drug Utilization Review Program<br>A.1. | The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims. |
| 1927(g)(1)(A) | | 2. | The DUR program assures that prescriptions for outpatient drugs are:<br><br>-Appropriate<br>-Medically necessary<br>-Are not likely to result in adverse medical results |
| 1927(g)(1)(a) 42 CFR 456. 705(b) and 456.709(b) | | B. | The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, and patients or associated with specific drugs as well as:<br><br>-Potential and actual adverse drug reactions<br>-Therapeutic appropriateness<br>-Overutilization and underutilization<br>-Appropriate use of generic products<br>-Therapeutic duplication<br>-Drug disease contraindications<br>-Drug-drug interactions<br>-Incorrect drug dosage or duration of drug treatment<br>-Drug-allergy interactions<br>-Clinical abuse/misuse |
| 1927(g)(1)(B) 42 CFR 456.703 (d) and (f) | | C. | The DUR program shall assess date use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:<br><br>-American Hospital Formulary Service Drug Information<br>-United State Pharmacopeia-Drug Information<br>-American Medical Association Drug Evaluations. |

REVISION: HCFA-PM-93-3 (MB)
March 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.26 | Drug Utilization Review Program |
|---|---|---|
| 1927(g)(1)(D)<br>42 CFR 456.703(b) | D. | DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never–the-less chosen to include nursing home drugs in:<br><br>/ / Prospective DUR<br>/X/ Retrospective DUR |
| 1927(g)(2)(A)<br>42 CFR 456.705(b) | E.1. | The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient. |
| 1927(g)(2)(A)(i)<br>42 CFR 456.705(b)<br>(1)-(7) | 2. | Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:<br><br>-Therapeutic duplication<br>-Drug-disease contraindications<br>-Drug-drug interactions<br>-Drug-interactions with non-prescription or over-the-counter drugs<br>-Incorrect drug dosage or duration of drug treatment<br>-Drug allergy interactions<br>-Clinical abuse/misuse |
| 1927(g)(2)(A)(ii)<br>42 CFR 456.705<br>(c) and (d) | 3. | Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles. |
| 1927(g)(2)(B)<br>42 CFR 456.709(a) | F.1. | The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:<br><br>-Patterns of fraud and abuse<br>-Gross overuse<br>-Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs. |

REVISION: HCFA-PM-93-3 (MB)
March 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.26 | Drug Utilization Review Program (cont.) |
|---|---|---|
| 1927(g)(2)(C)<br>42 CFR 456.709(b) | F.2. | The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:<br><br>-Therapeutic appropriateness<br>-Overutilization and underutilization<br>-Appropriate use of generic products<br>-Therapeutic duplication<br>-Drug-disease contraindications<br>-Drug-drug interactions<br>-Incorrect drug dosage/duration of drug treatment<br>-Clinical abuse/misuse |
| 1927(g)(2)(D)<br>42 CFR 456.71 1 | 3. | The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices. |
| 1927(g)(3)(A)<br>42 CFR 456.716(a) | G.1. | The DUR program has established a State DUR Board either:<br>/X/ Directly, or<br>/ / Under contract with a private organization |
| 1927(g)(3)(B)<br>42 CFR 456.716<br>(A) and (B) | 2. | The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:<br><br>-Clinically appropriate prescribing of covered outpatient drugs.<br>-Clinically appropriate dispensing and monitoring of covered outpatient drugs.<br>-Drug use review, evaluation and intervention.<br>-Medical quality assurance. |
| 1927(g)(3)(C)<br>42 CFR 456.716(d) | 3. | The activities of the DUR Board include:<br><br>-Retrospective DUR,<br>-Application of Standards as defined in section 1927(g)(2)(C), and<br>-Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR. |

REVISION: HCFA-PM-93-3 (MB)
March 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.22 | Drug Utilization Review Program (cont.) | |
|---|---|---|---|
| 1927(g)(3)(C)<br>42 CFR 456.711 (a)-(d) | | G.4. | The interventions include in appropriate instances.<br><br>-Information dissemination<br>-Written, oral and electronic reminders<br>-Face-to-Face discussions<br>-Intensified monitoring/review of prescribers/dispensers |
| 1927(g)(3)(D)<br>42 CFR 456.712<br>(A) and (B) | | H. | The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report. |
| 1927(h)(1)<br>42 CFR 456.722 | / / | I.1. | The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:<br><br>-real time eligibility verification<br>-claims data capture<br>-adjudication of claims<br>-assistance to pharmacists, etc. applying for and receiving payment. |
| 1927(g)(2)(A)(i)<br>42 CFR 456.705(b) | | 2. | Prospective DUR is performed using an electronic point of sale drug claims processing system. |
| 1927(j)(2)<br>42 CFR 456.703 (c) | | J. | Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities are drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such' covered outpatient drugs. |

REVISION: HCFA-PM-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.27 | Disclosure of Survey Information and Provider or Contractor Evaluation |
|---|---|---|
| 42 CFR 431.115 (c)<br>AT-78-90<br>AT-79-74 | | The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115. |

REVISION: HCFA-PM-93-1 (BPD)
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.28 | Appeals Process |
|---|---|---|
| 42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)). | (a) | The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154. |
| | (b) | The State provides an appeals system that meets the requirements of 42 CPR 431 Subpart E, 42 CPR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C. |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 1902(a)(4)(C) of the Social Security Act P.L. 105-33 | 4.29 | Conflict of Interest Provisions<br><br>The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code. |
| 1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58 | | The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423). |

REVISION: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
October 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CFR 1002.203<br>AT-79-54<br>48 FR 3742<br>51 FR 34772 | 4.30 | Exclusion of Providers and Suspension of Practitioners and Other Individuals<br><br>(a) All requirements of 42 CFR Part 1002, Subpart B are met.<br><br>/ / The agency, under the authority of State law, imposes broader sanctions. |

REVISION: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
October 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals (cont.)

(b) The Medicaid agency meets the requirements of --

1902(p) of the Act

(1) Section 1902(p) of the Act by excluding from participation --

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

42 CFR 438.808

(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that --

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

1932(d)(1)
42 CFR 438.610

(2) An MCO, PIHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance, the State will comply with the requirements of 42 CFR 438.61.(c).

REVISION: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
October 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

455.103
44 FR 41644
1902(a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940
through 435.960
52 FR 5967

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

REVISION: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
October 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

REVISION: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
October 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

4.34 Systematic Alien Verification for Entitlements

1137 of the Act P.L. 99-603 (sec. 121)

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/ / The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/X/ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/X/ Total waiver

/ / Alternative system

/ / Partial implementation

Washington will use approved verification procedures, e.g., reviewing the documents that the client holds.

REVISION: HCFA-PM-90-2 (BPD) OMB No.: 0938-0193
January 1990

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | |
|---|---|---|---|
| | 4.35 | | Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation |
| 1919 (h) (1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a)) | | (a) | The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A) (i) through (iv) of the Act. |
| | / / | | Not applicable to intermediate care facilities; these services are not furnished under this plan. |
| | /X/ | (b) | The agency uses the following remedy(ies): |
| | | | (1) Denial of payment for new admissions. |
| | | | (2) Civil money penalty. |
| | | | (3) Appointment of temporary management. |
| | | | (4) In emergency cases, closure of the facility and/or transfer of residents. |
| 1919(h)(2)(B)(ii) of the Act | / / | (c) | The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use. |
| 1919(h)(2)(F) of the Act | / / | (d) | The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents: |
| | | / / | (1) Public recognition. |
| | | / / | (2) Incentive payments. |

- See attachment 4.35 A

REVISION: HCFA-PM-95-4 (HSQB)
June 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation 4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402 (f )

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402 (f) .

(i) The notice (except for civil money penalties and State monitoring) specifies the:
(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404(b)(i)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404 (b) (1) & (2).

/ / The State considers additional factors. Attachment 4.35-A describes the State's other factors.

REVISION: HCFA-PM-95-4 (HSQB)
June 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation 4.35 Enforcement of Compliance for Nursing Facilities (cont.)

(c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417 (b) §1919 (h) (2) (C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919 (h) (2) (D) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919 (h) (2) (A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408 (c) (2), §488.408 (d) (2), and §488.408 (e) (2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412 (a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412 (a) are not met.

(d) Available Remedies

42 CFR §488.406 (b) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).§1919 (h) (2) (A)

/X/ (1) Termination
/X/ (2) Temporary Management
/X/ (3) Denial of Payment for New Admissions
/X/ (4) Civil Money Penalties
/X/ (5) Transfer of Residents; Transfer of Residents with Closure of Facility
/X/ (6) State Monitoring

Attachments 4.35-H through 4.35-G describe the criteria for applying the above remedies.

REVISION: HCFA-PM-95-4 (HSQB)
June 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | | |
|---|---|---|---|---|
| | 4.35(d) | Enforcement of Compliance for Nursing Facilities (cont.) | | |
| 42 CFR §488.406 (b) §1919 (h) (2) (B) (ii) of the Act. | | (ii) / / | | The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406 (b). |
| | | / / | (1) | Temporary Management |
| | | / / | (2) | Denial of Payment for New Admissions |
| | | / / | (3) | Civil Money Penalties |
| | | / / | (4) | Transfer of Residents; Transfer of Residents with Closure of Facility |
| | | / / | (5) | State Monitoring |
| | | Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them. | | |
| 42 CFR §488.303 (b) 1910 (h) (2) (F) of the Act. | | (e) / / | | State Incentive Programs |
| | | / / | (1) | Public Recognition |
| | | / / | (2) | Incentive Payments |

REVISION: HCFA-PM-91-4 (BPD) OMB No.: 0938-
June 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.36 | Required Coordination Between the Medicaid and WIC Programs |
|---|---|---|
| 1902(a)(11)(C) and 1902(a)(53) of the Act | | The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act. |

Revision:

State WASHINGTON

| Citation | 4.36 | Prescribed Drug Reimbursement |
|---|---|---|
| 1927(a)(2) | | The State will meet all reporting and provision of information requirements as specified in Section 1927(a)(2). |

There are no pages 79f through 79m

REVISION: HCFA-PM-91-10 (BPD)
December 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | |
|---|---|---|---|
| 42 CFR 483.75; 42 CPR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P. L. 101-508 (Sec. 4801(a)). | 4.38 | | Nurse Aide Training and Competency Evaluation for Nursing Facilities |
| | | (a) | The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met. |
| | / / | (b) | The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b) (1). |
| | /X/ | (c) | The State deems individuals who meet the requirements of 42 CFR 483.150(b) (2) to have met the nurse aide training and competency evaluation requirements. |
| | | (d) | The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154. |
| | / / | (e) | The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152 |
| | /X/ | (f) | The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154. |

REVISION: HCFA-PM-91-10 (BPD)
December 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities (cont.) | |
|---|---|---|
| 42 CFR483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)). | (g) | If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request. |
| | (h) | The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met. |
| | (i) | Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met. |
| | (j) | Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met. |
| | (k) | For program reviews other than the initial review, the State visits the entity providing the program. |
| | (l) | The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b) (2) and (3). |

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| Citation | | | |
|---|---|---|---|
| | 4.38 | | Nurse Aide Training and Competency Evaluation for Nursing Facilities (cont.) |
| 42 CPR 483.75; 42 CPR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)). | | (m) | The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor. |
| | | (n) | The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years. |
| | | (o) | The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification). |
| | | (p) | The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b) (2) or (3). |
| | /X/ | (q) | The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154. |
| | | (r) | The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State. |

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| Citation | | 4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities (cont.) |
|---|---|---|
| 42 CFR 483.75; 42 CFR 483 Subpart D; Seca. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)). | | (s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval. |
| | | (t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program. |
| | | (u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program. |
| | | (v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry. |
| | | (w) Competency evaluation programs are administered by the State or by a State -approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid. |
| | /X/ | (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR483.154(d). |
| | | (y) The State has a standard for successful completion of competency evaluation programs. |

REVISION: HCFA-PM-91-4 (BPD) OMD No.: 0938-
August 1991

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| Citation | | 4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities (cont.) | |
|---|---|---|---|
| 42 CFR 483.75; 42 CFR 483 Subpart D; 30 Secs. 1902(a) (28), 1919(e) (1) and (2) and 1919(f) (2), P.L. 100-203 (Sec. 4211(a) (3)); P.L. 101-239 (Secs. 6901(b) (3) and (4)); P.L. 101-508 (Sec. 4801(a)). | | (z) | The State includes a record of successful completion of a competency evaluation within days of the date an individual is found competent. |
| | /X/ | (aa) | The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3). |
| aide 483.156. | | (bb) | The State maintains a nurse registry that meets the requirements in 42 CFR |
| | / / | (cc) | The State includes home health aides on the registry. |
| | / / | (dd) | The State contracts the operation of the registry to non State entity. |
| the | /X/ | (ee) | ATTACHMENT 4.38 contains State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156 (c) (1) (iii) and (iv). |
| the | /X/ | (ff) | ATTACHMENT 4.38-A contains State's description of information included on the registry in addition to the information required by 42 CFR 483.156 (c). |

REVISION: HCFA-PM-93-1 (BPD)
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | | |
|---|---|---|---|
| Secs 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)). | | 4.39 | Preadmission Screening and Annual Resident Review in-Nursing Facilities |
| | | (a) | The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c). |
| | | (b) | The State operates a preadmission and annual resident review program that meets the requirements of 42 CPR 483.100-138. |
| | | (c) | The State does not claim as “medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed. |
| | | (d) | With the exception of NF services furnished to certain NF residents defined in 42 CPR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services. |
| | /X/ | (e) | ATTACHMENT 4.39 specifies the State's definition of specialized services. |

REVISION: HCFA-PM-93-1 (BPD)
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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4.39 Preadmission Screening and Annual Resident Review in-Nursing Facilities (cont.)

/X/ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

REVISION: HCFA-PM-92-3 (HSQB) OMB No.:
April 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

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| Citation Sections | | 4.40 Survey & Certification Process |
|---|---|---|
| 1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a)) | (a) | The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met. |
| 1919(g)(1)(B) of the Act | (b) | The State conducts periodic education programs for staff and residents (and their representatives). **Attachment 4.40-A** describes the survey and certification educational program. |
| 1919(g)(1)(C) of the Act | (c) | The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. **Attachment 4.40-B** describes the State's process. |
| 1919(g)(1)(C) of the Act | (d) | The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? Department of Health |
| 1919(g)(1)(C) of the Act | (e) | The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry. |
| 1919(g)(1)(C) of the Act | (f) | The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility. |

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April 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.40 | Survey & Certification Process |
|---|---|---|
| 1919(g)(2)(A)(i) of the Act | (g) | The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. **Attachment 4.40-0** describes the State's procedures. |
| 1919(g)(2)(A)(ii) of the Act | (h) | The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than15 months after the date of the previous, standard survey. |
| 1919(g)(2)(A)(iii)(I) of the Act | (i) | The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months. |
| 1919(g)(2)(A)(iii)(II) of the Act | (j) | The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility. |
| 1919(g)(2)(B) of the Act | (k) | The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion. |
| 1919(g)(2)(C) of the Act | (l) | The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary. |

REVISION: HCFA-PM-92-3 (HSQB) OMB No.:
April 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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| Citation | 4.40 | Survey & Certification Process (cont.) |
|---|---|---|
| 1919(g) (2) (D) of the Act | (m) | The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. **Attachment4.40-D** describes the State's programs. |
| 1919(g) (2) (E) (i) of the Act | (n) | The State uses a multidisciplinary team of professionals including a registered professional nurse. |
| 1919(g) (2) (E) (ii) of the Act | (o) | The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed. |
| 1919 (g) (2) (E)(iii) of the Act | (p) | The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification , techniques approved by the Secretary. |
| 1919(g) (4) of the Act | (q) | The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. **Attachment 4.40-E** describes the State's complaint procedures. |
| 1919(g) (5) (A) of the Act | (r) | The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act. |
| 1919(g) (5) (B) of the Act | (s) | The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility. |
| 1919(g) (5) (c) of the Act | (t) | If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board. |
| 1919(g) (5) (D) of the Act | (u) | The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions. |

REVISION: HCFA-PM-92-3 (HSQB)
April 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 4.41 | Resident Assessment for Nursing Facilities | |
|---|---|---|---|
| Sections 1919(b)(3) and 1919 (e)(5) of the Act | (a) | The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act. | |
| 1919(e)(5) (A) of the Act | (b) | The State is using: | |
| | | / / | the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§l919(e)(5)(A)]; or |
| 1919(e)(5) (B) of the Act | | /X/ | a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)]. |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10 (a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

/ / The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

5.2 Reserved

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 42 CPR Part 432, Subpart B<br>AT-78-90 | 5.3 | Training Programs; Subprofessional and Volunteer Programs<br><br>The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers. |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

SECTION 6 FINANCIAL ALMINISTRATICN

| Citation | | |
|---|---|---|
| 42 CFR 433.32<br>AT-79-29 | 6.1 | Fiscal Policies and Accountability<br><br>The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met. |

REVISION: HCFA-AT-81 (BPP)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | | |
|---|---|---|
| 47 CFR 433.34<br>47 FR 17490 | 6.2 | Cost Allocation<br>There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 C R Part 95, Subpart E. |

REVISION: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation

42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in buoth assistance and administration.

/ / State funds are used to pay all of the non-Federal share of total expenditures under the plan.

/X/ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services of level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State an a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

REVISION: HCFA-PM-91-4 (BPD)
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

SECTION 7 - GENERAL PROVISIONS

| Citation | 7.1 Plan Amendments |
|---|---|
| 42 CFR 430.12(c) | The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation. |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 7.2 | Nondiscrimination |
|---|---|---|
| 45 CFR Parts 80 and 84 of the | | In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. sea.), Section 504 Rehabilitation Act of 1973 (29 U.S.C. 70b), and regulations at 45 CFR Parts 80 and 84, the agency assures that no individual shall be discrimination under this plan on the grounds of color, national origin, or handicap. The Medicaid agency has methods of assure that each program or activity for which it receives Federal financial assistance will be in accordance with title VI regulations. These for title VI are described in ATTACHMENT 7.2-A. |
| | the Medicaid subject to race, administration to operated methods | |

REVISION: HCFA-PM-91-4 (VPD) OMB No.: 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

| Citation | 7.3 | Maintenance of AFDC Efforts |
|---|---|---|
| 1902(c ) of the Act | /X/ | The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988. |

REVISION

State/Territory: WASHINGTON

| Citation | 7.4 | State Governor's Review |
|---|---|---|
| 42 CFR 430.12(b) | | The Medicaid agency will provide opportunity for the office of the Governor to review State plan amendments, long-range program planning projections, and other periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents. |

/X/ Not applicable. The Governor--

/X/ Does not wish to review any plan material.

/ / Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of:

THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Designated Single State Agency),

Date:-July 1, 2000

/s/ signed
(Signature) DENNIS BRADDOCK
(Title) Secretary